



Assessment of the National Vitamin A Supplementation and De-worming Program in Tanzania

Assessment Report

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Acronyms and Abbreviations

AED	Academy for Educational Development
CCHP	Comprehensive Council Health Plan
CHMT	(District) Council Health Management Team
CHW	Community health worker
CORPs	Community-owned resource persons
DCCO	District Cold Chain Officer
DRCHCo	District Reproductive and Child Health Coordinator
EPI	Expanded Programme on Immunization
FGD	Focus group discussion
HKI	Helen Keller International
HMIS	Health management information system
IEC	Information, education and communication
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Stores Department
NBS	National Bureau of Statistics
NGO	Non-governmental organization
PEC	Post Event Coverage (survey)
RCCO	Regional Cold Chain Operator
RCHMT	Regional Council Health Management Team
RMO	Regional Medical Officer
RRCHCo	Regional Reproductive and Child Health Coordinator
TDHS	Tanzania Demographic and Health Survey
TFNC	Tanzania Food and Nutrition Center
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VAC	Vitamin A capsule
VAD	Vitamin A deficiency
VAS	Vitamin A supplementation

I. Executive Summary

Helen Keller International (HKI) has supported the vitamin A supplementation (VAS) and de-worming program in the United Republic of Tanzania (mainland) since 2003. With the support of the Academy for Educational Development's A2Z Micronutrients and Childhood Blindness Project from 2006 to 2011, HKI in partnership with Tanzanian government agencies, local organizations and other international NGOs and bi-lateral organizations to support sustainable and high coverage of vitamin A supplementation and de-worming throughout the country.

HKI contracted WellShare International to lead an assessment of this project from March to June 2011. The purpose of this assessment was to:

- Identify the strengths and weaknesses of the current vitamin A supplementation and de-worming program in Tanzania at the national, regional, district and health facility levels.
- Identify and map out the roles and responsibilities of the different organizations, government agencies and administrative levels involved.
- Identify the activities being implemented and the levels and types of resources required to effectively implement these activities.
- Examine the data reporting system and available data on service outputs (including routine VAS and post partum VAS provision) and trends in coverage.
- Consolidate the materials developed on Tanzania's VAS program into a library.

The Assessment Team led focus group discussions with 195 mothers and interviewed 87 representatives from government, nongovernmental and multilateral agencies covering seven regions of mainland Tanzania. In addition, Assessment Team members reviewed a wide range of project-related documents including reports, policy statements, training/education materials and quantitative data. Results were shared and discussed by the Assessment Team and a group of leading policy makers and program managers who identified the following key findings and recommendations:

Summary Findings

- VAS and de-worming is an identified health priority of the MoHSW and is included in each district's CCHP.
- Planning and budgeting tools developed by HKI/A2Z are being utilized at the regional and district levels throughout the country.
- Project produced VAS IEC materials are well received and utilized. The supply needs to be increased to ensure better saturation at the most remote areas.
- HKI/A2Z-facilitated zonal meetings have provided nationwide opportunities to share successes/challenges and for technical training and data collection.
- Mothers expressed satisfaction in the availability of VAS and de-worming at the twice yearly events

- When asked about the successes of the HKI/A2Z Project, District CHMT members noted an increase in community knowledge about and acceptance of VAS, especially as they sensitized and mobilized religious, political and community leaders through meetings.
- The need for further expansion of VAS distribution continues, especially in the more remote villages and hard to reach communities that have limited access to services

Summary Recommendations

- Institute 3-point strategy to improve child survival and enhance on-going comprehensive child health initiatives:
 - Strategy 1: Continue twice yearly VAS events reinforced by a strengthened and expanded IEC promotional campaign that starts well before the events. Twice yearly VAS should be regarded as routine health service provided over the entire months of June and December.
 - Strategy 2: Expand VAS distribution and coverage by incorporating VAS with all other outreach and clinic based campaigns and services, for instance measles campaigns, well-baby checks, and other activities and services identified by communities and providers where there is access to children between 12 and 59 months of age.
 - Strategy 3: Engage trained community volunteers (i.e. CORPs, TBAs, village health committee members, etc.) in dispensing vitamin A capsules (VAC) between the twice yearly events
- Consolidate and formalize the various coordinating bodies in Tanzania involved in nutrition and micronutrients into a single entity administered by the TFNC and holding regularly scheduled meetings (e.g. quarterly).
- Provide front-line health workers with additional and on-going technical training, refresher training and supportive supervision on VAS through zonal and regional meetings, and “in-service” training during routine supportive supervision.

II. History, Description and Program Structure

The consumption of foods containing beta carotene has been known to cure night blindness since the first century A.D. in Egypt. However, it was not until 1913 that a nutritionist, E.V. McCollum, first isolated vitamin A as an essential micronutrient. Sixty years later research led by Dr. Alfred Sommer in Indonesia and later in Nepal found that vitamin A was also one of the most effective means of preventing child and maternal mortality. The World Bank has since judged the vitamin A capsule (VAC) one of the most cost-effective medical interventions of all time.¹ The 2008 Copenhagen Consensus ranked micronutrient supplements (specifically VAS and therapeutic zinc supplementation for diarrhea) as the top development priority out of more than 40 interventions considered.²

Vitamin A deficiency (VAD) is a public health problem in 118 countries and an estimated 127 million children less than five years of age worldwide are vitamin A deficient.³ Because of vitamin A's role in the development of the immune system, each year up to 647,000 vitamin A-deficient, pre-school-aged children die from infections, such as measles and diarrhea, from which they would otherwise survive.⁴ VAD is also the leading cause of preventable blindness in children.

The Academy for Educational Development's (AED) A2Z Project was established by a cooperative agreement with the U.S. Agency for International Development (USAID) to save and improve the lives of women and children through state-of-the-art micronutrient and child blindness programs. A2Z's country programs strive to strengthen and expand existing programs that deliver micronutrients to individuals to address vitamin and mineral deficiencies through supplementation and food fortification. In the United Republic of Tanzania (mainland), AED's A2Z Project has been implemented by its partner Helen Keller International (HKI), in close collaboration with the Tanzania Food and Nutrition Center (TFNC), from 2006 to 2011. There HKI has worked with Tanzanian government agencies, local organizations, and other international NGOs to improve micronutrient intakes, specifically for vitamin A, zinc and iron folate.

In 1987 Tanzania began including vitamin A capsules (VAC) in kits distributed through the Essential Drugs Program to government-run primary health care facilities. To increase coverage, vitamin A supplementation (VAS) was introduced into routine immunization services (EPI) in 1997 and the sub-national measles immunization campaigns in 1999 and 2000. Twice-yearly distribution was initiated in 2001 for children aged 6-59 months as part of two popular annual events: Day of the African Child (June) and World AIDS Day (December). Distribution of de-worming tablets was added to these

¹ http://www.pbs.org/wgbh/rxforsurvival/series/champions/alfred_sommer.html

² Horton, Sue; Begin; France; Greig, Alison; and Lakshman, Anand. *Micronutrient Supplements for Child Survival (Vitamin A and Zinc)*. Copenhagen Consensus Center. 2008.

³ Rice, Amy et al. Vitamin A Deficiency. *Comparative Quantification of Health Risks Global and Regional Burden of Disease Attributable to Selected Major Risk Factors, Volume 2*. (WHO, 2004) p. 249

⁴ *Ibid*, p. 249.

events in December 2004.⁵ Direct support to the district councils for VACs and de-worming programs was provided by UNICEF beginning in 2001.

In 2007 UNICEF direct financing of VAS was concluded to comply with the Government of Tanzania's adoption of a policy of decentralization. From that point district level councils were responsible to utilize other funding, including donor-generated basket funds, to cover the costs of VAS special events. Each district council is now responsible for developing its own annual Comprehensive Council Health Plan (CCHP), based on the CCHP guidelines developed by the central level MoHSW, and assisted by a representative from their Regional Council Health Management Team. The CCHP must be based on 11 national health priorities, and include district health priorities, activities related to the implementation of all public health services and line-item budgets including sources of funding.

III. Assessment Purpose and Objectives

The purpose of this assessment was to complete a thorough review of the National Vitamin A Program through June 2011 using a desk review, stakeholder interviews and focus group discussions (FGD) to:

- Identify the strengths and weaknesses of the current vitamin A supplementation program in Tanzania at the national, regional, district and health facility levels.
- Identify and map out the roles and responsibilities of the different organizations, government agencies and administrative levels involved.
- Identify the activities being implemented and the levels and types of resources required to effectively implement these activities.
- Examine the data reporting system and available data on service outputs (including routine VAS and post partum VAS provision) and trends in coverage.
- Consolidate the materials developed on Tanzania's VAS program into a library.

The findings and recommendations from this report, and inputs from the Advisory Group meeting and the "Workshop for Policy Makers and Program Managers on Sustainability of the National VAS and De-worming Program in Tanzania" were used in the design of the accompanying Long Term Strategy for VAS in Tanzania.

IV. Assessment Methodology

HKI contracted with WellShare International to lead this assessment effort from March 17, 2011 to June 10, 2011. WellShare International is a US-based non-profit organization with over 30 years of experience designing, implementing and evaluating community-based primary health care programs, in line with its mission to improve the health of women, children and their communities around the world.

⁵ Assessment of the Sustainability of the Tanzania National Vitamin A Supplementation Program. 2008. A2Z Project, Academy for Educational Development, Washington DC.

Work on this final assessment commenced with a review of project documents (reports, assessments, quantitative data, training materials, meetings minutes, etc.) provided by the HKI team in Tanzania, Government of Tanzania policy on micronutrients, technical materials on Vitamin A, and other pertinent documents. (See Attachment A for a list of documents reviewed.) (The HKI/A2Z Project, however, lacked a framework listing the goal, results and objectives it was setting out to achieve or a set of indicators to monitor its progress and evaluate its impact. HKI noted that their annual work plans included monitoring indicators, however, these were not made available to the Assessment Team for review.) All of these documents were consolidated, cataloged and copied for libraries housed at both HKI's and TFNC's offices in Dar es Salaam after the conclusion of the project.

Information collected from the project's written record and discussions with senior project staff were used to develop FGD and interview guides for use by members of the Assessment Team. WellShare and HKI staff then met to determine the number and choice of regions to visit for the community, district and regional interviews and FGDs.

Purposeful sampling was used to select regions so that the cohort would provide as representative a picture of the entire country as possible with regard to VAS. Criteria for selecting regions included:

1. Overall coverage rates reflecting the nation-wide range: highest, mean and lowest.
2. Geographical coverage so as many of Tanzania's eight mainland zones were represented as possible.
3. Population density, including a rural and urban mix.
4. Level of health care infrastructure
5. Logistical challenges – infrastructure and distance between health facilities within the region

The assessment team anticipated using the 2010 Tanzania Demographic and Health Survey (TDHS) as the key to determining the regions to be visited during the assessment. Based on a review of the TDHS data, the assessment team initially recommended Iringa and Shinyanga Regions in the assessment. Iringa had the highest VAS coverage at 84% and Shinyanga had the lowest at 11%. Following a review of the Administrative data reported by TFNC, Dar es Salaam was also included because of its size and unique characteristics, and continuous low performance. HKI staff supported the inclusion of these three regions with the recommendation of an additional three regions (Rukwa, Tabora and Manyara) based on their VAS coverage rates 2001-2010. Both data sets (Administrative and TDHS) confirmed the addition of Rukwa, Manyara and Tabora to the list (based on the criteria noted above; see also Table 1).⁶

Field work began on April 13, 2011 with initial meetings with the MoHSW, TFNC and HKI in Dar es Salaam. Regional field work followed. Districts and communities were selected jointly by the regional and district officials, respectively, along with members of

⁶ Shinyanga Region is the most populated rural region in the country. Manyara is a newly formed region.

the Assessment Team using purposeful sampling with criteria similar to that used at the regional level. Focus group discussions were held at the community level involving mothers and using an interviewer guide and sample VACs so mothers would recognize them. The Field Team also attended the Northern Zone Stakeholder's meeting held on April 6 to interview the Regional Reproductive and Child Health Coordinators for Tabora, Arusha, and Kilimanjaro Regions.

Table 1. Schedule and location of assessment field work.

Dates / RCH Zones	Region	Reasons for Selection	Districts	Communities
April 6 Northern	Arusha, Tanga, Kilimanjaro	Participation in Zonal Stakeholder's meeting	Interview of Regional RCH Coordinator's at Northern Zone Stakeholder's Meeting	
April 13-15 Eastern	Dar es Salaam	Unique urban setting	Meetings with national offices of the MoHSW, TFNC and HKI	
	Dar es Salaam		Temeke	Temeke
Eastern	Dar es Salaam		Ilala	Ilala Regional Hospital
April 18-19 Central	Manyara	New region	Babati	Babati Town
Central	Manyara		Hanang	Endasaki and Nangwa Villages
April 20-21 Lake	Shinyanga	Low coverage/high population	Kishapu	Mwanuru and Mangu Village
Lake	Shinyanga		Kahama	Mwendakulima and Bukooba Village
April 26-29 Western	Tabora	Low coverage/ Location	Sikonge	Chabutwa Village
Western	Tabora		Tabora Municipal	Madaraka and Mtakuja Streets in Tabora Town
May 2-4 Southern Highlands	Rukwa	Unique, isolated, HKI suggestion	Sumbawanga Rural	Meangalua, Laela and Mtakujatunko Villages
Southern Highlands	Rukwa		Sumbawanga Urban	Isesa Street from Sumbawanga Town
May 6-7 Southern Highlands	Iringa	High coverage	Kilolo	Kilolo Village
Southern Highlands	Iringa		Iringa Rural	Igula and Ndiwili Villages

Dates / RCH Zones	Region	Reasons for Selection	Districts	Communities
May 13 Central	Manyara	Unique population	Simanjiro	Simanjiro Town
May 30	Dar es Salaam			Advisory Group meeting held
May 31-June 1	Dar es Salaam			Workshop of Policy Makers and Program Managers held Interviews with MoHSW

In sum, the Assessment Team met with:

- 195 mothers representing 19 communities
- 47 representatives from district government departments
- 31 representatives from regional government departments
- 5 representatives from the MoHSW including MSD, TFNC, EPI and Health Education
- 4 representatives from international and national NGOs and multi-/bi-laterals.

The Assessment Team facilitated a day-long meeting of the Advocacy Group on May 30, 2011 to review:

- HKI/A2Z project goals and objectives
- Partner roles
- Assessment methods and participants
- Assessment findings and recommendations
- The ‘way forward’ and long term planning for sustainability.

This was followed by a two-day seminar (May 31-June1) hosted by A2Z/HKI as a close out project activity and including representation from MoHSW, TFNC, international donors and regional and district health officials along with the Assessment Team. The objective of the 2-day seminar was to come to agreement on the long term national vision for VAS. This seminar covered:

- The current status of VAS and de-worming program.
- VAS coverage trends and recent coverage assessments
- The National VAS Program Assessment findings and recommendations included in this report.
- Discussion on options for incorporating 6-month VAS contact into routine EPI
- Discussion and building consensus on long term national VAS and de-worming vision including harmonization of twice yearly and routine VAS

V. Findings

The assessment findings are presented here in response to the assessment questions and delineated from the community level up to the national level.

Assessment Question 1

Identify the strengths and weaknesses of the current vitamin A supplementation program in Tanzania at the national, regional, district and health facility levels.

Table 2. Summary of Tanzania Vitamin A supplementation program strengths and challenges.

	Strengths	Challenges
National	<ul style="list-style-type: none"> • Uninterrupted continuation of VAS distribution throughout transition from direct UNICEF support to the districts over to the use of basket funding from the national government to the districts. HKI reports that over 95% of districts budgeted for VAS distribution in the CCHPs after this transition occurred. • VAS is an identified health priority of the MoHSW and therefore included in all District CCHP. • VAS ancillary activities are funded through health basket funds perceived by Districts and Regions as their most “reliable funding.” • The MoHSW is currently in the process of revising National policy and implementation guidelines for micronutrients and VAS programming and has designed (and will soon pilot) a new Child Health “booklet”. • Twice annual VAS special events are planned for, budgeted and carried out nationally. • Project-produced planning and budgeting tool utilized at the regional and district levels. • Project produced VAS IEC materials well received and utilized. • Zonal meetings resulted in opportunities to share successes/challenges and for technical training and data collection. 	<ul style="list-style-type: none"> • The lessons learned from VAS in Tanzania have yet to be fully utilized to improve comprehensive child health programming. • Long term VAD prevention not yet addressed (increased from 24% in 1997 to 35% in 2010). • Reliance on donor funds (including basket funds and UNICEF procurement of VACs and de-worming medicine) may not be sustainable. • High quality and well received HKI/A2Z IEC materials have been produced but supply insufficient to saturate communities and outlying areas. Consistent with finding that the main reason individuals did not attend the events was because of a lack of awareness. • At least five national level coordinating bodies are involved in some aspect of nutrition and/or micronutrients under the umbrella of the “Nutrition Multisectoral Working Group.” • Underutilization of existing nutrition-focused personnel at the district level (i.e. Ministry of Agriculture staff and Home Economics Officers). • Program sustainability is not solely based on available funding. Trained health staff, a strong M&E system, solid reporting are also necessary. • The project is using two different indicators to track coverage that results in different rates: PEC (68%) and TDHS (60%) versus VAS coverage based on tally sheets (98.5%).

	Strengths	Challenges
National	<ul style="list-style-type: none"> Plans to increase national-level nutrition focus through the placement of Nutritionists at the regional and district levels. 	<p>While the most accurate measure of coverage requires a community-level survey, this is also the most labor-intensive and costly method. While comparing the number of VAC distributed through VAS to the population is the most frequently used measure by health systems worldwide, it may over estimate true coverage and does not identify more isolated communities.</p>
District / Region	<ul style="list-style-type: none"> HKI/A2Z 2010. Post Event Coverage (PEC) Survey – Mainland Tanzania, June 2010. <ul style="list-style-type: none"> 86% of health workers know that VAS prevents blindness 90% of health workers know that children 6-59 months are a target group for VAS Health workers reported that the supply of VAC and de-worming tablets has improved as a result of HKI/A2Z. Planning and budgeting tools developed by HKI were useful and can be modified for use on other interventions as well. District level ‘ownership’ led to innovation (i.e. Babati Rural and Iringa Rural Districts) and use of local resources (i.e., community radio stations). Regional priorities can be set and met (i.e., Manyara). Zonal coordination meetings applauded as an important forum to: <ul style="list-style-type: none"> discuss challenges and successes identify key partners to involve in VAS distribution including community leaders and FBOs plan and participate in the annual events strengthen their reporting systems increase the level of collaboration between the districts, regions, TFNC and MoHSW 	<ul style="list-style-type: none"> Limited budgets and resources now and questionable for the future. PEC survey data from 2010 found: <ul style="list-style-type: none"> 76% of health workers said they had a role in administering VAS and only 17% were responsible for recording this in tally sheets Only 55% of health workers know that VAS strengthens the child’s immune system Only 19% of health workers know that production and consumption of vitamin A rich foods will help prevent VAD Only 5% of health workers know that children with infections are a target group for receiving VAS Only 2% of health workers know that malnourished children are a target group for receiving VAS The packaging of the VACs in 500 unit packs complicates its distribution (now being addressed by UNICEF) Limited human resources at the region and district levels impacts service delivery especially in remote areas and areas without health facilities Many districts report shortages of VACs and delivery delays for scheduled events Some districts/regions unaware of upcoming end of HKI/A2Z project; there remains concern at the district level on the future of VAC procurement

	Strengths	Challenges
Community	<ul style="list-style-type: none"> • Mothers expressed satisfaction in the availability of VAS at the twice yearly events. • District CHMT members noted an increase in community knowledge about and acceptance of VAS, especially as they sensitized and mobilized religious, political and community leaders through meetings. • Positive involvement of leaders at all levels in mobilization and sensitization on VAS twice yearly events. • Community ownership of VAS (Simanjiro District) • Mothers displayed knowledge of the importance on VAS • Mothers committed to bringing the children of family, friends to VAS events if their mothers are not available. • Mothers appreciate that health services have been brought “a bit” closer during VAS special events • Utilization of CHWs to sensitize and mobilize community members 	<ul style="list-style-type: none"> • Remote villages and hard to reach communities have limited access to services. • Existing VAS coverage reports do not provide adequate analysis to determine coverage in remote and underserved areas. • Poor attendance at twice annual events may be caused by distances to travel and the limited number of health workers (impacting the allocation of outposts). • Persistent rumors that VAS events are being used to dispense family planning and the side effects from the 2008 bilharzia campaign were identified by mothers as reasons why some are not attending the events. • PEC survey data (2010) found: <ul style="list-style-type: none"> - Low levels of knowledge about what foods contain vitamin A - Only 5% of respondents found out about the VAS campaigns from posters (project IEC materials) - Primary reason respondents said they did not attend the events was because they were not informed - 58% of CHWs reported being responsible for administering VAS - Only 18% of CHWs knew production and consumption of vitamin A-rich foods will help prevent VAD - Missed opportunities for provision of health services - Long-term (food based) VAD prevention not yet addressed

National Level

Each of the key players at the national level brought a different perspective to the question of strengths and weaknesses, depending on their agency’s role and experience with the project. The most consistently mentioned success was the seamless continuation of VAS distribution throughout the transition from direct UNICEF support to the districts over to the use of basket funding. HKI’s assessment found that over 95% of districts budgeted for VAS distribution after the transition in their CCHPs. There was much concern prior to and during this transition that VAS would be overlooked or omitted from CCHPs because of the nature of VAC being a relatively low-demand intervention.

HKI/A2Z provided training and advocated with district and regional health authorities on the importance of incorporating VAS distribution into their CCHPs at the zonal coordination meetings. HKI/A2Z developed a computerized spreadsheet tool that CHMTs use for planning and budgeting VAS and de-worming distribution in their CCHPs and a monitoring tool it has used to track the incorporation of VAS and de-worming distribution into district CCHPs and budgets nationwide. USAID has expressed interest in the possibility of using these tools to track the real-time allocation and use of financial resources tied to a range of health interventions and services, and to the “scaling up” of the lessons learned from the implementation of this tool to other child health interventions.

The 2010 TDHS reports that VAD increased in Tanzania from 24% in 1997⁷ to 34% in 2010.⁸ In response HKI/A2Z staff noted that “VAS was not implemented to decrease VAD. The focus was to have an impact on childhood morbidity and mortality.”⁹ They further noted that twice yearly VAS events will have little or no impact on VAD because the resulting improvement in vitamin A status is transient and can vary widely based on a child’s health status, where sick children require more frequent VAS than well children. This leaves a significant gap between one event and the next. Given this inherent shortcoming in the intervention it is critical that resources be extended to fill the gap in the schedule and speed the transition to fortification and nutritional strategies that can provide a long-term resolution to these gaps.

The TFNC noted that while the quality of the IEC materials developed by HKI/A2Z has been excellent, the supply was insufficient to meet the need required to saturate the communities and reach the more outlying areas. This is consistent with the finding that the leading reason individuals reported missing the events was due to lack of awareness.¹⁰

Regional Level

Representatives from the regional level reported that HKI/A2Z provided IEC materials, organized the zonal meetings that have been helpful in coordinating VAS activities, developed a tool which has been useful for the planning of VAS activities, provided technical training on VAS at the beginning of the project, and provided supportive supervision throughout. It was generally agreed that these led to increased coverage and improved health overall in each of their respective regions. Regional representatives noted the same budgetary challenges as those mentioned in the districts, recognizing the need for sensitizing district council members, government and political leaders at all levels to the fundamental importance of VAS and ensuring that it continues to be prioritized beyond the life of A2Z.

⁷ HKI/Tanzania. *Vitamin A Supplementation & De-worming: Post Event Coverage Survey-2010. Tanzania Mainland. Draft Report on Research Findings.* April 2011.

⁸ TDHS. 2010.

⁹ It should also be noted that the biomarkers used to evaluate VAD (serum retinol levels vs. retinol binding protein) differed from those used in 2010 and therefore comparability is not straightforward

¹⁰ HKI/Tanzania. *Vitamin A Supplementation & De-worming: Post Event Coverage Survey-2010. Tanzania Mainland. Draft Report on Research Findings.* April 2011.

District and Health Facility Level

Representatives from several of the districts surveyed noted declines in mortality, morbidity (diarrhea and measles) and malnutrition, which is attributed in part to the success of the VAS and de-worming campaigns. While not without further challenges, they also reported that the supply of VAS and de-worming tablets has improved as a result of HKI/A2Z, which had led directly to these improvements in the health of the population and their ability to provide services.

CHMT members also highlighted the ways that the HKI/A2Z program and the Tanzania Food and Nutrition Center (TFNC) provided technical training, improved their own coordination and increased their own capacity. The zonal coordination meetings were universally applauded as an important forum to share challenges and successes; identify key partners to involve in VAS distribution (i.e., FBOs and community leaders); plan and participate in the special events; strengthen their reporting systems; and increase the level of collaboration between the districts, regions, TFNC and MoHSW. There was broad consensus that these meetings should continue and it was announced at the Stakeholder's Workshop in May that HKI has secured funding from CIDA to continue VAS work and will continue with zonal meetings. Some have reported not only using the planning tools HKI developed for VAS, but also using them to develop plans and budgets for other intervention areas. Though designed specifically for VAS and de-worming activities, the tool provides a detailed planning and budgeting process which can be modified and utilized for other child health initiatives and for review of budget submissions by district councils and Regional Health Management Teams. A 'bottom-up approach' was found to be beneficial in the long run as it ensured local buy-in and support for the program and its budget in the district councils.

The primary challenges at the health facility and district levels have largely centered on adjusting to the budget cuts that have accompanied the decentralization process. For VAS this has meant a switch from direct UNICEF funding over to the identification of other funding sources, health basket funds from the national government. The basket funds allow for much greater discretion and flexibility by the district councils in what services they will provide in their district. They are also considered a more "reliable" source of funding and less likely to suffer budget cuts. Ensuring that VAS remains a priority and is sufficiently financed throughout Tanzania's districts has been an important concern and focus of HKI/A2Z since this change was instituted.

Although the level of funding available from the central government has been cut back from the proposed ceiling for most districts, HKI/A2Z research and this assessment have found that districts are including VAS in their annual CCHPs and budgets, and linking the funding for these activities to the more reliable basket funds. Because of this there is general consensus that the project benefits are sustainable in the long run.¹¹ Overall budget cuts and shortages of trained health professionals, however, have contributed to understaffing and logistical challenges affecting all health programming, including VAS and de-worming distribution. Some districts have had to delay the twice annual events,

¹¹ Assessment of the Sustainability of the Tanzania National Vitamin A Supplementation Program

while others have cut back on the allowances that local leadership need in order to support and participate in the events, resulting in limited outreach and coverage.

District representatives mentioned that the VAS and de-worming orders from the Medical Stores Department (MSD) have not always arrived on time and are frequently insufficient to meet the demand. One of the reasons they stated was the use of National Bureau of Statistics (NBS) population projection figures to estimate the quantities needed and for ordering the supplies. Almost unanimously the districts mentioned that NBS underestimates the actual population by not reflecting significant changes due to migration and increasing birth rates. They also do not factor in use of health care services by foreign nationals. This was noted in Rukwa, a region that borders Zambia

For many areas, especially in the Western and Southern Highland zones, the timing of the December World AIDS Day event during the raining season also makes the transport of supplies and the setting up of remote outposts a greater challenge. Stock shortages and delays at health facilities and the events are also due to the limited availability of vehicles and staffing at the district level necessary to transport the VAS and de-worming supplies to the outlying areas.

The packaging of the VACs in 500 unit packs further complicates its distribution to the health facilities and outposts since these packs are difficult to break up. This is currently being addressed by UNICEF globally, with possible pilot studies to test 100 unit packets conducted in Tanzania. Also the limited availability of 100,000IU capsules for children under one year of age can result in waste and imprecise dosing of children when the 200,000IU capsules must be cut to provide partial doses.

While most of these challenges go beyond the limitations of the districts to address on their own, representatives from several districts expressed a commitment to reach out to local, national and international resources and across sectors to expand and facilitate VAS and de-worming distribution. This will include more prominent use of radio to communicate IEC messages and announcements; proactively seeking international donor and NGO partner support of distribution activities; taking a ‘no-missed opportunity’ approach to educating the public on the importance and availability of VAS through health and other sectors of the government (i.e. education, agricultural extension, etc.); and, seeking greater engagement from community leaders, elected officials, traditional providers and local NGO/CBO/FBOs in all aspects of health care delivery so they are more cognizant of and vested in health outcomes. Though these are significant challenges, the district representatives unanimously noted that the HKI/A2Z program provided them with the tools that significantly contributed to their ability to pursue these solutions.

Community Level

The vast majority of mothers participating in the focus group discussions said they had taken their children to the most recent Day of the African Child and/or World AIDS Day events, where their children had received VAS and de-worming. They expressed general satisfaction for the services they had received. In fact, rather than referring to these events

by their formal names, the mothers called them ‘special days for VA’ or ‘*matone*,’ the Swahili word for ‘drops.’ The few who did not attend said their children had already received VAS and de-worming through routine immunization and clinic visits.

“*‘Matone’ helps children grow!*”

(*Matone is the Swahili word for ‘drops.’*)

A mother participating in a FGD

The mothers said they had learned about the events and vitamin A in general from local leaders, posters, community announcements, health workers, and by radio and TV in the more urban areas. This was corroborated by health workers and representatives from the District Council Health Management Teams (CHMT) who noted that they had seen an increase in community knowledge about and acceptance of VAS, especially as they had begun to work more cooperatively with religious, political and community leaders, most notably in Sikonge District and Tabora Municipality in Tabora Region, Sumbawanga Urban in Rukwa Region, and Simanjiro District in Manyara Region. However, mothers also noted that many in the communities still do not understand the importance of VAS and are not aware of its availability at no cost at the events so more education and outreach is still needed. This is consistent with the USAID mission’s concern that expanding coverage to the more remote areas of the districts was an on-going challenge that needs further attention. Mothers also said it would be helpful if announcements could start going out earlier before the events so they would have enough time to adequately prepare to go since it can take up an entire day.

Some communities have exerted extra initiative. In Babati District, village competitions have been used to spark interest and increase coverage. The District provides three trophies for the top three performing villages and certificates of accomplishment to their leaders. Iringa District has utilized their own funds to purchase 100 bullhorns which the health facilities are using to communicate health announcements, including VAS events.

“In order for the VAS and de-worming to be successful the whole community should participate, instead of seeing it as the responsibility of women alone.”

A mother participating in a FGD

The main challenges mothers faced in getting to the events and health care services in general is the time it takes away from their domestic responsibilities, compounded by the lack of support they receive from their spouses. Many have to travel two to three hours each way; wait

times at the events or health posts range from a few minutes up to two hours because of the lack of sufficient staffing. The mothers reported that their husbands do not understand the importance of VAS and generally consider the preventive and routine health issues of their children to be the sole responsibility of the mothers.

In several of the focus groups, mothers mentioned that there is a lot of skepticism in the communities about immunizations in general, due to rumors that tetanous toxoid and VAS are being used to promote contraceptives and that the government’s bilharzia (praziquantel issues) program from 2008 resulted in several children becoming sick.

Health workers and district officials also reported hearing the same rumors. In FGDs, mothers said that the health workers were addressing these rumors and misunderstandings through community meetings. Health workers also relayed that they are frequently asked why VAS has to be done every six months, unlike immunizations. The coupling of VAS with de-worming, for which the positive benefits are more readily apparent to the mothers, has most definitely helped improve VAS coverage.

The mothers had several recommendations for how VAS and de-worming distribution and the events could be improved upon and made more participant-friendly:

- Community leaders should promote the idea that the events are important activities for which mothers should be relieved of their domestic responsibilities so they can attend. This can also help to ensure that sufficient time and flexibility is afforded so both parents can take their children to the events.
- Consideration should be given to lengthening the events from a single weekend (with a single day in some more remote outposts) to multiple days, especially in the many remote areas. This would allow mothers more flexibility in when they can attend and thus increase coverage. Starting the announcements for the events earlier would also help increase attendance.
- Traditional healers, traditional birth attendants and community leaders can play critical roles in educating mothers, engaging fathers and dispelling rumors on VAS and de-worming.
- Make more health staff available at the events in order to cut back on the longer wait times.
- The distribution of IEC materials should be expanded so more people know about the importance of VAS especially and that it is available for free at the events and at health facilities during routine visits.

“Whenever VAS activities are delayed we call and write to the district leadership to find out what is wrong and insist the event be scheduled as soon as possible...”

The Masaai women of Simanjiro District, Manyara Region

Assessment Question 2

Identify and map out the roles and responsibilities of the different organizations, government agencies and administrative levels involved.

Roles and responsibilities for VAS distribution span from the household to the national government (see Figure 1). Families are responsible for knowing when their members need to seek health care, including VAS, and then seeking that care at the appropriate times. Community leaders, educators, and mainstream and traditional health care providers are responsible for promoting the importance of VAS and making sure caregivers and other appropriate individuals know when and where it is available and supporting them in seeking it.

The primary responsibility for VAS distribution at the district level is in the hands of the VAS focal person which is either the District Cold Chain Officer (DCCO) or the District Reproductive and Child Health Coordinator (DRCHCo). They set distribution targets and initiate orders for VAC through TFNC to the MSD (based on NBS data); prepare VAS/de-worming-specific budgets and plans for the CCHP; organize, conduct and report on VAS activities for special events; coordinate and monitor the transfer of VAC/de-worming tablets to health facilities and outposts. They are directly supervised and supported by the District Medical Officer and the other members of each district's CHMT, and indirectly by technical experts at the regional and national levels.

The Regional Council Health Management Team has direct oversight and responsibility for all health related programming in their region, including VAS and de-worming. The RMO's office ensures that district-level staff have knowledge of government health priorities. It is also the role of the RMO to supervise health-related activities in the region including VAS activities, and to provide technical support to ensure that district implementation is in sync with national policies and guidance. One member of the Regional Council Health Management Team joins in the planning process with the District Council Health Management Team; the Regional Cold Chain Operator (RCCO) and RRCHCo also facilitate training and assist in the budgeting process in developing their CCHP.

The key players at the national level involved with VAS include the Tanzanian Food & Nutrition Center (TFNC) of the MoHSW, UNICEF, the Medical Stores Department (MSD), HKI/A2Z Project and several other donors and coordinating bodies. TFNC was established in 1985 as the lead Tanzanian Government agency responsible for policy development, the overall coordination of nutrition and food related services, and capacity building related to nutrition and micronutrients. UNICEF is responsible for the procurement of VACs for special events throughout Tanzania and the MSD is responsible for its warehousing and distribution from the national to the district level.

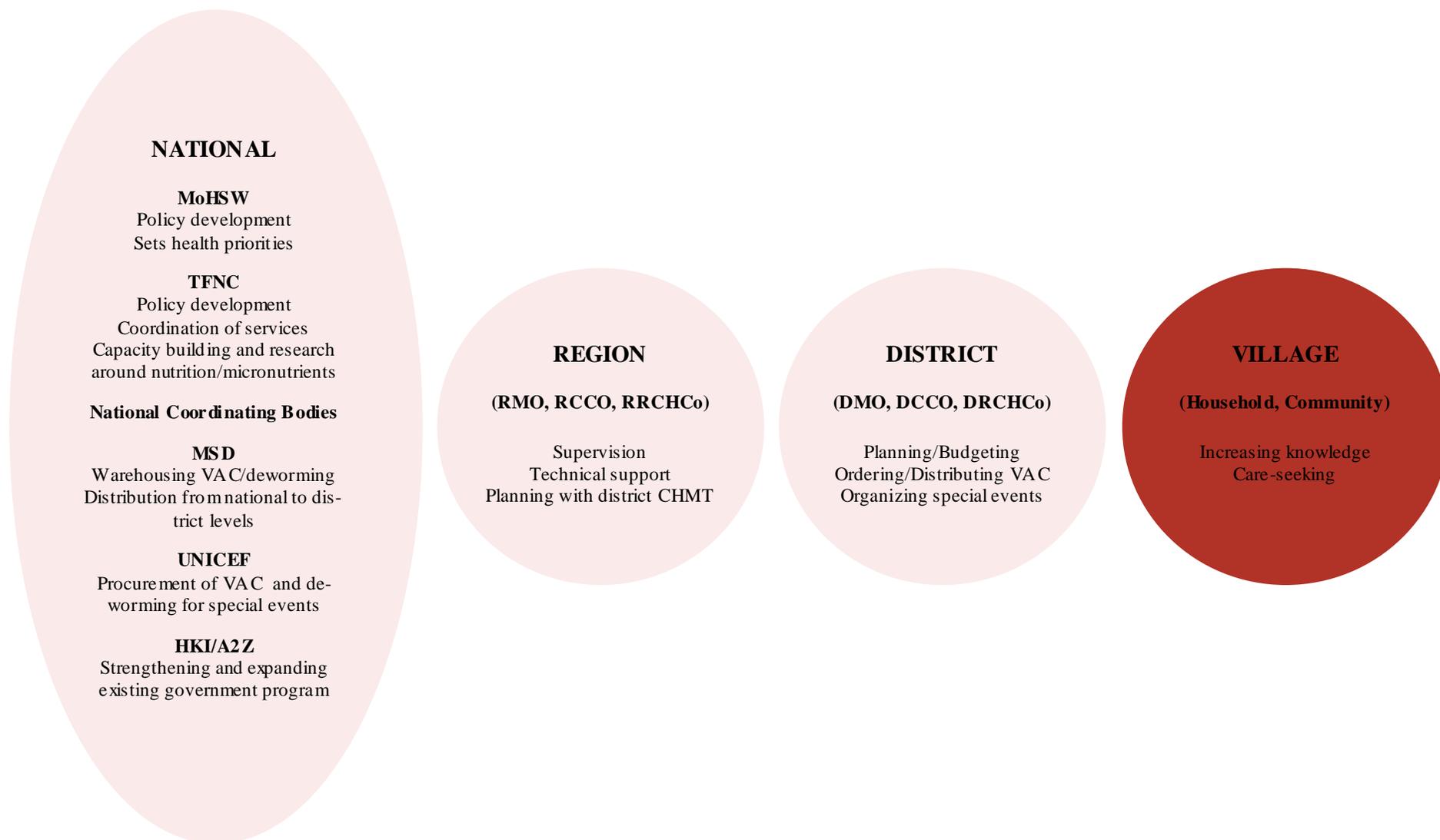


Figure 1. Roles of key stakeholders in Tanzania’s vitamin A supplementation program.

Intra-agency coordination at the national level has been a challenge throughout the project. There are currently at least five working groups, task forces and consultative groups involved with various aspects of nutrition and micronutrients, including the VAS Task Force, the Anemia Consultative Working Group, the National Food Fortification Alliance and many others, which can result in unnecessary duplication and difficulties in coordination. Many of these entities were established with donor support and although they are supposed to come under a single umbrella group this structural relationship has never been formalized and they only come together periodically and inconsistently.

The budgeting process starts at the grassroots with villages proposing their priorities for health. These are then consolidated at the ward level and taken by the district as a blueprint for developing their CCHP in collaboration with at least one member of the Regional Health Management Team. The RHMT member advises the district on the national health priorities as they relate to the needs expressed by the district and then provides recommendations based on national policy, priorities and budget ceilings. The budget and CCHP are then submitted to the district counsel for review, deliberations, adjustment and approval. Once approved, the CCHP is submitted to the central government for further review, adjustment and final approval. It should be noted that the approved budget may be subject to further cuts based on government revenue and resources. Many districts surveyed said their CCHP review is rejected at the regional level if it does not include a line item for VAS.

Assessment Question 3

Identify the activities being implemented and the levels and types of resources required to effectively implement these activities.

The following activities are being implemented presently, as HKI/A2Z’s program is coming to a close and project responsibilities are being turned over to local counterparts and partners. Together they constitute the basic components of a nation-wide VAS program.

Table 3. Roles and responsibilities of Vitamin A supplementation partners.

	Activity	Responsible Parties	Resources Required
National	Ensure adequate stocks of VAC available in country.	UNICEF, MSD and TFNC	Manufacture and/or importation.
	Forecast target population estimates (based on NBS projections), fill orders and transport VAC to districts.	MSD and TFNC	Transport of VAC to districts.
	Organize and facilitate semiannual Zonal Meetings.	TFNC and A2Z/HKI	Conference facility Lodging for participants
	Provide national facilitation during events,, TA and training to Regional Focal Person on VAS. Ensure compliance with National Micronutrient Policy.	MoHSW and TFNC	Included with the semiannual Zonal Meetings above.

	Activity	Responsible Parties	Resources Required
	Update National Micronutrient Policy based on monitoring of national VAS distribution and developments in the science of micronutrients.	MoHSW and TFNC	N/A
Region	Provide supportive supervision, TA and training to the Regional Focal Persons on VAS, including input on development of district CCHP.	RCCO	Transport and per diem from the RMO's office to each of the DMOs offices throughout the region.
	Participate in the semiannual Zonal Coordination meetings	RCCO and RMO	Transport and per diem from RMO's office to the Zonal Coordination meetings.
	Report regional level distribution of VAS to the MoHSW.	RCCO and RMO	Reporting formats
District	Educate health workers, religious leaders, traditional healers, etc. on the importance of VAS and where/when to get it.	DCCO, DRHC	Available transport from DMO's office to health facilities and events.
	Ensuring the supply and distribution of VAS and IEC materials to health facilities and events through review of inventories and submission of orders to the MSD.	DCCOs	VAS supplied to the district from the MSD. IEC materials. Transport and per diem from DMO's office to health facilities and events.
	Report district level distribution of VAS to the CHMT and RHMT.	DCCO and DMO	Reporting formats
	Provide supportive supervision to staff at health facilities and health workers at events.	DCCO	Transport and per diem from DMO's office to health facilities and events.
	Plan, budget and advocate for VAS in the CCHP.	DCCO, DMO, and RCCO	Planning and budgeting templates
Community	Educate parents, care givers and pregnant women on the importance of VAS and where to get it.	Health workers, community leaders, religious leaders, traditional healers, etc.	IEC materials, radio/TV station announcements, etc.
	Provide VAS to children and postpartum women at health facilities.	Parents, care givers, pregnant women, and health workers.	Access to a staffed health facility that has VAS in stock.
	Provide VAS to children at annual events	Parents, care givers, and health workers.	Access to annual events where VAS is available and being provided.

Assessment Question 4

Examine the data reporting system and available data on service outputs (include routine VAS and postpartum VAS provision) and trends in coverage.

There has been much discussion and debate about the level of coverage achieved by the project and the population totals used to compute coverage. It is important to realize that

two different indicators are being used to measure ‘coverage.’ UNICEF defines VAS coverage as “the percentage of children ages 6-59 months old who received at least one high-dose vitamin A capsule in the previous six months.”

A majority of health care systems worldwide use a ratio as a surrogate or proxy measure of coverage, not only for vitamin A distribution, but also for mosquito nets, immunizations and other services provided or supplies distributed to a population. The project has used the number of children given a VAC for the numerator and the estimated total population of children 6-59 months living in the district for the denominator to compute coverage. While this can result in a close approximation to the actual coverage rate, it is technically a ratio because it is comparing two different variables: the number of children who attend an event and receive a VAC compared with the estimated total population of children living in the area. An inherent problem with this ratio surfaces when accurate census numbers are not available. The district census figures are provided by the NBS, whose estimates tend to be low when compared to the actual population, which then results in an over estimation of coverage.

Based on this measurement method, Tanzania averaged 95.3 VAC distributed during each event for every 100 children 6-59 months of age living in Tanzania from the beginning of A2Z to date. (See table below.)

Table 4. Vitamin A supplementation distribution data (2001-2010).

Year	June – Day of the African Child			December – World AIDS Day			Notes
	Beneficiary Population	VAS Distributed	Ratio X:100	Beneficiary Population	VAS Distributed	Ratio X:100	
2001	4,816,828	4,645,323	96.4	n/a	n/a	112.1	First year VAS distributed @ events.
2002	n/a	n/a	112.8	n/a	n/a	114.4	
2003	n/a	n/a	110.2	n/a	n/a	107.1	HKI began working on VAS as part of the MOST Project in Tanzania
2004	5,260,645	5,671,480	107.8	5,174,196	5,600,707	108.2	Added de-worming tablets at events
2005	n/a	n/a	116.8	6,766,801	5,534,592	81.8	TDHS VAS coverage rate: 46%
2006	6,454,530	6,109,043	94.6	6,392,081	5,958,284	93.2	First year HKI/A2Z project in Tanzania
2007	6,497,582	6,139,493	94.5	6,829,539	6,462,961	94.6	Last year of direct UNICEF support to districts for

Year	June – Day of the African Child			December – World AIDS Day			Notes
	Beneficiary Population	VAS Distributed	Ratio X:100	Beneficiary Population	VAS Distributed	Ratio X:100	
							VAS
2008	6,542,442	6,320,365	96.6	6,542,442	6,101,024	93.3	
2009	6,653,205	6,269,561	94.2	6,653,442	6,530,036	98.1	
2010	6,711,755	6,626,367	98.7	n/a	n/a	n/a	TDHS VAS coverage rate: 60.3%. PECS coverage rate 65.4%
2011							HKI/A2Z Project ends May 2011

While much more expensive and time-consuming than the other method, a population-based survey done shortly after distribution is recognized as the most accurate measure of coverage.¹² This was done by HKI/A2Z in 2010 and reported in April 2011 – The Post Event Coverage (PEC) Survey. The PEC survey found 65% coverage. Tanzania’s most recent TDHS found a coverage rate of 60.3% in 2010. The overall tendency for measuring VAS with these tools is to undercount actual coverage, especially if children without cards are assumed to not have received VAS. Accepting caregiver recall is one way that this has been corrected for.

Comparing these two indicators can be useful to determine the effectiveness of the distribution. Ideally the difference between the distribution:population ratio and the coverage rate should narrow over the course of a project, as the effectiveness and targeting of the distribution improves, especially into hard-to-reach populations. This appears to have been the case in the HKI/A2Z Project where the national coverage rate increased from 46% in 2004/5 to 60% in 2010, while the ratio of VAS distributed to population remained relatively the same from 2006 (93.9:100) to 2009/10 (98.4:100).

The Assessment Team found that consistency of reporting has been an on-going challenge. TFNC’s release of national level data can be delayed when they have to wait for a region’s report. Delayed supply requests to the MSD can result in delays in the arrival of VAC for the monthly VAS events. Further, submission of monthly and quarterly reports by HKI/A2Z to AED was inconsistent through 2008 and appeared to stop entirely at that point through the remainder of the project, replaced by intermittent reports on various topics related to VAS.

Assessment Question 5

Consolidate the materials developed on Tanzania’s VAS program into a library.

See Appendix A.

¹² Houston, R; Greig, A; et al. *Vitamin A Supplementation Coverage: Using Rapid Post-event Surveys and Other Methods to Examine Coverage and Strengthen VAS Programmes*. Global Alliance for Vitamin A (GAVA).

VI. Recommendations

Since this is a summative final assessment, the recommendations provided here are directed primarily at the partnering organizations and agencies that will be responsible for sustaining the achievements of A2Z in Tanzania.

Recommendation 1: Institute 3-point strategy to improve child survival and enhance on-going comprehensive child health initiatives:

- **Strategy 1:** Continue twice yearly VAS events reinforced by a strengthened and expanded IEC promotional campaign that starts well before the events. Twice yearly VAS should be regarded as routine health service provided over the entire months of June and December.
- **Strategy 2:** Expand VAS distribution and coverage by incorporating VAS with all other outreach and clinic based campaigns and services, for instance measles campaigns, well-baby checks, and other activities and services identified by communities and providers where there is access to children between 12 and 59 months of age.
- **Strategy 3:** Engage trained community volunteers (i.e. CORPs, TBAs, village health committee members, etc.) in dispensing VAC between the twice yearly events

Recommendation 2: Twice yearly VAS should continue to be implemented in conjunction with nutrition based programs that improve household diet AND the expansion of food fortification programs is essential to improving national nutrition (with a special emphasis on rural food fortification).

Recommendation 3: Incorporate the following revisions into the VAS program monitoring and evaluation process:

- Systematic random monitoring spot checks to ensure that VAS reaches most remote areas, conducted by RHMT members.
- Strengthening of HMIS system for reporting routine VAS at all levels
- Validation of coverage data by population-based surveys (e.g. PEC survey and TDHS).

Recommendation 4: Consolidate and formalize the various coordinating bodies in Tanzania involved in nutrition and micronutrients into a single entity administered by the TFNC and holding regularly scheduled meetings (e.g. quarterly). Membership should include representation from partner ministries (i.e. the Ministries of Health and Social Welfare, Agriculture, Community Development, Education, etc.) and other stakeholders. Separate sub-committees should be established focusing on specific technical areas (VAS, zinc, food fortification, etc.)

Recommendation 5: Provide front-line health workers with additional and on-going technical training, refresher training and supportive supervision on VAS through zonal and regional meetings, and “in-service” training during routine supportive supervision. Topics should include:

- Therapeutic VAS for the sick and malnourished child
- Provision of VAS for postpartum women
- Data collection and reporting
- Food fortification and diet modification

Recommendation 6: Twice yearly VAS activities should be planned utilizing district-level population estimates rather than NBS data.

Recommendation 7: RHMT should budget for the supportive supervision of twice yearly VAS separately from routine supportive supervision.

Recommendation 8: Rapid post-distribution community level surveys should be done as frequently as possible (every other year) and the results compared to the data collected through the project tally sheets.¹³

¹³ Ibid.

Appendix A – Documents Reviewed and Catalogued for the Project Library

The documents listed below were reviewed for the assessment and included in the project library (see corresponding zip file of documents).

#	Item
Helen Keller International – Project Documents	
A1	Annual Report 2007
A2	Annual Report 2008
A3	Annual Report 2009
A4	Annual Report 2010
A5	District Planning and Budgeting Table for VAS (23Mar2010)
A6	Training guideline on PBT (10 Nov 2007)
A7	Tanzania VAS 8 th Oct 2010 HKITz
A8	Cost Analysis of the National Twice-Yearly Vitamin A Supplementation Program in Tanzania, MOST: The USAID Micronutrient Program, May 2005
A9	Update on VAS coverage and funding 24Oct07
A10	VASDEW CCHP Funding Analysis Jan 2011
A11	Report on Population Based Assessment on Vitamin A Supplementation and Deworming Coverage in four A2Z Project Districts in Tanzania, By Joseph K.L Mugyabuso and Temina A. Mkumbwa (HKI Tanzania) January 2007
A12	Tanzania Vitamin A Supplementation: Comparison of Coverage Estimates with Tally Sheet, Program Survey and DHS Data. May 2009. By Joseph Mugyabuso, Robin Houseon, Nadra Franklin and Veronica Lee. The Micronutrient and Child Blindness Project.
A13	VASD Post Event Coverage Survey Mainland Tanzania 2010 (April 2011)
A14	Report on the Annual Reproductive and Child Health Meeting on Vitamin A Supplementation and Deworming, November 9 to December 1 December 2010, Helen Keller International Tanzania
A15	District Budget and Nutrition Activities Report for CCHP 2010-2011
A16	Assessment of the Sustainability of the Tanzania National Vitamin A Supplementation Program
A17	Sustainability Assessment Tools for Vitamin A Supplementation
A18	DeWorming Dosage Card (Kiswahili) Job AID

A19	Vitamin A Dosage Card Job Aid (Kiswahili)
A20	VAS Poster (Dec 2007)
A21	Translation of Poster and IEC (English versions)
A22	Vitamin A Factsheet (English and Swahili)
Republic of Tanzania – Policy/Working Documents	
A23	National Micronutrient Supplementation Policy (in revision)
A24	National Vitamin A Supplementation Implementation Guidelines (updated 2010)
A25	Essential Package of Nutrition Interventions at the District Level January 2008
A26	Tanzania National Nutrition Strategy: June 2009 – June 2015 (Final Draft March 2011)
A27	Terms of Reference for the Technical Working Group on Nutrition
National Vitamin A Supplementation in Tanzania – Assessment Consensus Documents	
A28	Statement of Consensus from the Workshop for Policy Makers and Program Managers on Sustainability of the Tanzania Mainland Vitamin A Supplementation and De-worming Program and Subsequent Zonal Meetings.
Other Relevant Documents	
A29	District Nutrition Toolkit (July29.10) (UNICEF)
A30	Tanzania DHS 2010 Report
A31	Tanzania DHS 2005 Report

Appendix B – Assessment Team Members

The Assessment Team for the National Vitamin A Supplementation Program in Tanzania comprised the following members:

WellShare International

Jolene Mullins, Field Team Lead
Innocent Augustino Nduhura, Field Team
Silvery Tesha, Field Team
Garth Osborn, Technical Team Lead
Laura Ehrlich, International Team Lead

Helen Keller International

Dr. Christina Nyhus Dhillon
Tumaini Bakobi
Temina Mkumbwa
Margaret Benjamin

Academy for Educational Development

Jariseta Rambelason Zo

National Advisory Board

Dr. Subilaga Kazimoto, Nutrition Focal Person, MoHSW
Dr. Generose Mulokozi, PFS, TFNC
James Mwambalangua, Regional Cold Chain Officer, Lindi
Dr. Paul Choate, District Medical Officer, Hai District
Dr. Shaib Maarfa, District Medical Officer, Iringa Town Council

Appendix C – Respondents

Region	District	Village	Name of Respondent(s)	Title/Position
Arusha, Tanga, Kilimanjaro			N/A	Regional RCH Coordinators from Tanga, Kilimanjaro and Arusha Regions
Dar es Salaam	Temeke	Temeke Regional Hospital	N/A	14 randomly selected women with children under 5
Dar es Salaam	Ilala	Ilala District Council	Sister Mary Sobayi	District RCH Coordinator
Dar es Salaam			Dr. Subilaga Kazimoto	Nutritional Focal Person, MoHSW
Dar es Salaam			Dr. Dafrossa C. Lyimo	EPI, MoHSW
Dar es Salaam			Dr. Generose Mulokozi	Vitamin A Coordinator, TFNC
Dar es Salaam			Mr. Beatus Msoma	Vertical Programme Manager, MSD
Dar es Salaam			Dr. Raz Stevenson	MCH Project Manager, USAID/Tanzania
Dar es Salaam			Dr. Harriet Torlesse	Nutrition Manager, UNICEF
Dar es Salaam		City Council	Dr. Hawa Kawawa	Programme Manager
Dar es Salaam		City Council	Sr. Zukrah Mkwizu	Regional Reproductive and Child Health Coordinator
Manyara	Babati	Babati Town	Mr. Chita Halid	District Cold Chain Officer
Manyara	Babati	Babati Town	Dr. Godwin O. Mallel	Regional Medical Officer
Manyara	Babati	Babati Town	Mr. Manazo Sulleman	Regional Cold Chain Officer
Manyara	Babati Urban	Megamsi Street		6 randomly selected women with children under 2
Manyara	Hanang	Endasaki		10 randomly selected women with children under 5
Manyara	Hanang	Nangwa		10 randomly selected women with children under 5
Manyara	Simanjiro	Simanjiro Town	Dr. Ukio Kusirye	District Medical Officer
Manyara	Simanjiro	Simanjiro Town	Ms. Victoria Pemba	Deputy Reproductive and Child Health Coordinator
Manyara	Simanjiro	Simanjiro Town	N/A	10 randomly selected women with children under 2 and 10 randomly selected women with children under 5
Shinyanga	Shinyanga		Dr. Costa C. Muniko	Regional Medical Officer
Shinyanga	Kishapu	Mangu	N/A	25 randomly selected women with children under 2
Shinyanga	Kishapu	Mwanuru		

Region	District	Village	Name of Respondent(s)	Title/Position
Shinyanga	Kahama	Mwendakulima	N/A	20 randomly selected women with children under 2
Shinyanga	Kahama	Bukooba		
Tabora	Sikonge	Chabutwa Village	N/A	11 randomly selected women with children under 5
Tabora	Tabora Municipal	Tabora Town	Ms. Agnes Maijo	Regional Reproductive and Child Health Coordinator
Tabora	Tabora Municipal	Tabora Town	Mr. Bumija A. Muhando	Regional Cold Chain Officer
Tabora	Tabora Municipal	Tabora Town (Madaraka Street)	N/A	10 randomly selected women with children under 2
Tabora	Tabora Municipal	Tabora Town (Mtakuja Street)	N/A	10 randomly selected women with children under 2
Tabora	Sikonge District		Dr. Mathew S. Sipemba	Acting District Medical Officer
Tabora	Sikonge District		Sr. Suzana Mgaiwa	Assistant District Reproductive and Child Health Coordinator
Tabora	Sikonge District		Ms. Sara R. Kabuye	Acting District Nutrition Officer
Tabora	Sikonge District		Mr. Charles Ndungile	Assistant District Cold Chain Officer
Rukwa	Sumbawanga Rural	Meangalua	N/A	6 randomly selected women with children under 5
Rukwa	Sumbawanga Rural	Laela	N/A	6 randomly selected women with children under 5
Rukwa	Sumbawanga Rural	Mtakujatunko	N/A	6 randomly selected women with children under 5
Rukwa	Sumbawanga Urban	Sumbawanga Town	Dr. Salum Rashid Kabuma	Regional Medical Officer
Rukwa	Sumbawanga Urban	Sumbawanga Town	Mr. Zawadi Kamkono	Regional Cold Chain Officer
Rukwa	Sumbawanga Urban	Sumbawanga Town	Ms. Ester Kasegezya	Regional Nutrition Officer
Rukwa	Sumbawanga Urban	Sumbawanga Town (Isesa Street)	N/A	12 randomly selected women with children under 2
Iringa	Kilolo	Kilolo Town	Dr. Wilfred Rwechungura	District Medical Officer
Iringa	Kilolo	Kilolo Town	William Ndunguru	Health Officer
Iringa	Iringa Rural	Igula	N/A	7 randomly selected women with children under 5
Iringa	Iringa Rural	Ndiwili	N/A	7 randomly selected women with children under 5
Iringa	Iringa		Dr. Ezekiel Y. Mpuyo	Regional Medical Officer

Appendix D – Questionnaires

HKI/Tanzania Questionnaire

1. Planning: How were program activities planned at the start and annually thereafter?
 - a. Who was involved?
 - b. How were activities monitored?
2. Reporting: What are the supervisory/reporting relationship between the project and the following?
 - a. AED/Tanzania and AED/HQ
 - i. What has been the effect on the project of AED's recent difficulties? How are any negative effects being addressed?
 - b. HKI/Tanzania and HKI/HQ
 - c. MoHSW
 - d. USAID/Tanzania
3. How did HKI/Tanzania monitor VAS distribution at the district level events?
 - a. How were districts chosen for monitoring?
 - b. Was a supervisory checklist used/report written on the monitoring visit? Was feedback provided?
 - c. Suggest discussing the memo I sent on coverage rate versus distribution to population ratio.
4. How does HKI monitor and report on PP VAS distribution and/or coverage achieved?
5. What role has HKI had in promoting food fortification and alternative vitamin A sources (gardens, etc.)?
 - a. Current status
 - b. Future recommendations and plans
6. What role has HKI had in the development of the *National Micronutrient Supplementation Guidelines* (Reference pages 3-4 of the 2010 Annual Report)?
 - a. (Note: The draft Guidelines they shared with WellShare were dated August 2010 and comments/questions were inserted between February and April 2011.)
 - b. What is current MoPSW policy on initiating VAS for newborns and during ANC?
7. What is HKI's involvement in the following and who should we be talking to from the following list from the draft Policy Guidelines:
 - a. National Vitamin A Supplementation Task Force
 - b. National Fortification Alliance
 - c. Tanzania Bureau of Standards
 - d. Food and Drugs Authority
8. How many IEC posters did HKI print and distribute?
 - a. How was this number determined?

- b. What has been the follow up?
- 9. What are HKI's future plans in Tanzania and continuing to work on VAS?
- 10. What should be incorporated into the upcoming five year strategic plan?
 - a. What discussions has HKI had with the districts and others about this?
What are their views?
- 11. Who should we be talking to about:
 - a. Costing and budgeting VAS
 - b. Redoing the VAS packaging
 - c. Involvement in the planning
- 12. Request copies of the following:
 - a. Agreement with AED, including scope of work and any amendments
 - b. National level financial reports and budgets pertaining to VAS distribution
 - c. Most recent auditor's report covering A2Z.
 - d. Materials for the Library

MoHSW Staff and Follow up with TFNC
Questionnaire

NOTE: Suggest using this questionnaire for MoHSW staff outside of the TFNC who have not been interviewed on this evaluation yet. Suggest asking questions 1d, 3a-c, 4 and 6 when following up on the April 12th interview you had with Dr. Generose Mulokozi, (Programme Manager) and E. R. Rwiza (Senior Programme Officer) at TFNC.

1. What has been your role in the HKI A2Z Project?
 - a. What role did your office play in the design and monitoring of the A2Z project?
 - b. What reports do you receive from the A2Z project?
 - c. Has the MoHSW's relationship with HKI's A2Z Project been documented in an MOU or some other agreement?
 - d. What level and frequency of contact does your office have with HKI?
2. What have been HKI's main accomplishments in the A2Z project?
3. What discussions have there been with HKI on the future of VAS after the conclusion of the A2Z project?
 - a. Who was involved in these discussions?
 - b. How will your roles and responsibilities change as a result?
 - c. What lessons learned should be incorporated into the upcoming five year strategic plan for VAS distribution in Tanzania?
4. How is PP VAS distribution being promoted and monitored? What has HKI's role been in this?
5. What is the status on and future plans for vitamin A food fortification?
6. What role has HKI had in the development of the *National Micronutrient Supplementation Guidelines*?
 - a. Who is responsible for moving them through the approval process?
 - b. When will they be approved?
 - c. What is current MoPSW policy on initiating VAS for newborns and during ANC?
 - d. What is the status of the following and what roles and responsibilities do the members have? Who are the members?
 - i. National Vitamin A Supplementation Task Force
 - ii. National Fortification Alliance
7. Can you share budgets and financial reports pertaining to VAS distribution?
8. Who should we be talking to about:
 - a. How VAS import/manufacture, storage, transport and distribution are being financed from the national to the district/health facility/community levels?
 - b. Budgeting for VAS, including MoHSW, regional and district level VAS-related costs?
 - c. Redoing the VAS packaging

MSD
Questionnaire

1. What role has MSD had with the HKI A2Z Project?
 - a. What level and frequency of contact does MSD have with HKI?
2. Who are MSD's VAS suppliers?
 - a. How were they selected?
 - b. How long have they been used?
 - c. Have they always met their orders completely and on time?
 - d. Are alternative suppliers available?
 - e. How often does MSD have to reorder VAS on average?
 - i. Who initiates the order and how is it processed?
 - ii. Is the VAS manufactured in country or imported? If imported:
 1. How long does it usually take to clear customs?
 2. How much does it cost to clear customs?
 - iii. How long does it take for delivery of a new order from the supplier to the MSD?
 - iv. Is there a cost for warehousing VAS at the MSD? If so, how is it currently computed and funded?
 - f. Have there been any national level stock-outs of VAS in the past 5 years?
 - i. How many?
 - ii. How long?
 - iii. When was the most recent?
 - g. What is the cost for the MSD to purchase a supply sufficient to provide 7M children with one 100K IU dose of VAS?
3. Who initiates the orders to the MSD for VAS?
 - a. How long does it take to respond to an order?
 - b. Where does payment for the order come from?
 - c. Where does MDS deliver its VAS orders: MoHSW, CHMT, health facility, etc.?
 - d. What are your average annual transport costs for delivering VAS from the MSD to the field? Is this factored into the cost of the VAS or budgeted separately? If separately, what is the annual budget for the transportation and what is the source of this financing?
4. Can VAS be repackaged from cartons of 500 into cartons of 100 at the MSD? If so, what would be the cost?
5. Can you share budgets and financial reports pertaining to VAS distribution?

Regional Medical Officers (RMOs)
Questionnaire

1. What role and responsibilities does your office have in addressing micronutrient deficiencies and de-worming in your area?
 - a. Is this written into your regular plans and budgets?
 - b. Is this based on guidance from the MOHSW?
 - c. What support does your office provide to the districts on these areas?
 - d. What support does your office receive from other sources (MoHSW, multilaterals, A2Z, etc.?) on these areas?
2. Who does your office coordinate and work most directly with on this?
3. What have been the strengths of the A2Z program in your area?
4. What have been the challenges of addressing micronutrient deficiencies and de-worming in your area?
5. What role, if any, has the A2Z program had in helping you address these challenges?
6. What are the challenges of continuing micronutrient supplementation and de-worming after the conclusion of the A2Z program in your area?
7. How can these challenges be most effectively addressed?
8. What have been the most effective strategies for reaching children 6-59 months of age who have been missed by routine or event VAS? How are these children identified?

District Medical Officers (DMOs) and Members of the CHMTs
Questionnaire

1. What role and responsibilities does your office have in addressing micronutrient deficiencies and de-worming in your district?
 - a. Is this written into your regular CCHPs and budgets?
 - b. What support does your office provide to health facilities and communities on these areas? If there a designated person responsible for training on these topics?
 - c. What support does your office receive from other sources (MoHSW, RMOs multilaterals, A2Z, etc.?) on these areas?
 - d. Who is responsible for planning, administering and reporting on VAS/de-worming events? What support do they receive in carrying out their work? What other groups/organizations are involved?
 - e. Who is responsible for ordering restocks of supplies, supplements and medicines?
2. Who does your office coordinate and work most directly with on this in the health care system and the community?
3. What have been the strengths of the A2Z program in your area?
4. What have been the challenges of addressing micronutrient deficiencies and de-worming in your area?
5. What role, if any, has the A2Z program had in helping you address these challenges?
6. What are the challenges of continuing micronutrient supplementation and de-worming after the conclusion of the A2Z program in your area?
7. How can these challenges be most effectively addressed?
8. What have been the most effective strategies for reaching children 6-59 months of age who have been missed by routine or event VAS? How are these children identified?

What are the most effective ways for getting people to come to events that include supplementation/de-worming in your area? How do people learn when/where these events are happening?

Health Facility Staff
Questionnaire

1. Is your health facility involved in distributing VAS and/or de-worming medicines outside your facility, such as the annual Day of the African Child event in June or the World AIDS Day event in December?
 - a. If so, who plans and manages this activity?
 - b. How do you notify the community that VAS and/or de-worming medicines will be available during the events?
 - c. What groups or organizations are involved and how do they help?
2. What reasons do individuals decide not take or give their children VAS and/or de-worming medicine?
3. Has your staff received any training on VAS or other micronutrients/deworming medicine recently? How effective was the training?
4. Who is responsible for ordering vitamins and de-worming supplies? Do they arrive on time? Have there been any stock outs recently?
5. How are children who have not received VAS identified and followed up on?

Community Focus Group
Questionnaire

1. Who attended the most recent Day of the African Child event in June or the World AIDS Day event in December?
2. Why did you decide to attend?
3. How did you learn the event was happening?
4. Do you remember seeing whether someone was giving out free vitamins or de-worming medicines there?
5. If so, did you take any? Did you give them to your children? Why?
6. Why do some people decide not to get VAS and de-worming for their children or themselves?
7. For those of you who did not attend either of these events, what were the reasons? What would be a better place and time to give out these vitamins and medicine?
8. What can your community do to make sure every child and postpartum woman gets the necessary vitamins?

UNICEF
Questionnaire

1. What has been UNICEF's role in the HKI A2Z Project?
 - a. What role did UNICEF play in the design and monitoring of the A2Z project?
2. What is UNICEF's current role and involvement with VAS in Tanzania?
 - a. Is it still providing funding for the purchase of VAS? If so, how long will this continue and should it be included in the five year strategic plan?
3. What challenges and successes have been experienced as a result of the transition from direct UNICEF support going to districts for VAS over to the use of basket funds?
4. What level and frequency of contact has your office had with HKI?
5. What have been HKI's main accomplishments and challenges in the A2Z project?
6. What discussions have there been with HKI on the future of VAS after the conclusion of the A2Z project?
 - a. Who was involved in these discussions?
 - b. What lessons learned should be incorporated into the upcoming five year strategic plan for VAS distribution in Tanzania?

USAID/Tanzania
Questionnaire

1. Explain WellShare's expertise and capacity in doing evaluations and why WellShare was asked to do this evaluation:
 - a. Past evaluation experience (HealthPartners, Africare, Save the Children, etc.)
 - b. Skilled staff on the ground
 - c. Knowledge of the Tanzania health care system
 - d. Experience in MCH/PHC, including VAS programming,
2. Explain purpose of the evaluation.
3. What has been the mission's role and involvement with the A2Z project?
4. What are the future policy trends of the Tanzanian Gov't that will have an impact on VAS?
5. What lessons learned should be incorporated into the national VAS plan that will cover the next five years?
6. Is there anything they want to learn from this evaluation, (even though we're almost done with the data collection)?
7. Explain when, where and how the findings and recommendations will be shared.